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Antecedents of Spiritual Distress Experienced by Iranian Muslim Patients

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Abstract: The World Health Organization (WHO) has proclaimed that the definition of health includes four domains of well-being: Physical, mental, social and spiritual. It is therefore suggested, that nurses should prepare themselves to assist individuals and families not only to cope with illness and suffering, but also to find meaning in these experiences. The purpose of this investigation is to explore antecedents of spiritual distress experienced by Muslim patients in the Islamic context of Iran. Qualitative descriptive research was conducted using unstructured Interviews. Three main categories were found: Failure in communication, non-holistic care and inability to worship. The results showed that the patient's satisfaction could depend on good communication, good listening and good information. In ending, it can be said that staff members have a great deal of responsibility for assuring that the patient feels as good as possible, facilitating relatives' involvement based on the family's wishes and limiting the stress and difficulties experienced by the family.

Key words: Spiritual distress, experience, muslim, islam, patient, Iran

INTRODUCTION

The World Health Organization (WHO) (1998) has proclaimed that the definition of health includes 4 domains of well-being: Physical, mental, social and spiritual. In addition, nurses are the best witness of the impact of disease on a human being's life in his or her physical, affective, cognitive, social and spiritual dimensions.

The benefits of spiritual care in general health promotion have been promoted by Chapman (1986). They are broadening and enhancing the base of current nursing educational programs, making them more relevant to human beings; enhancing patients' values of health, which may improve patient satisfaction; ensuring programs are more effective catalysts of behavioral change and helping restore a balance between narrowly defined health issues and broader issues of living. As the literature addressing spiritual care increases, the merits of spiritual care are attracting more and more attention from nursing scholars. Thorough assessment is essential when delivering spiritual care. Key assessment areas include general and personal spiritual beliefs; indicators of spiritual distress or an opportunity for enhanced well-being; identification with a specific religion and spiritual or religious support systems and rituals (Trellor, 1999).

Carpenito (2002) lists spiritual distress-defined as "a disturbance in the belief or value system that provides strength, hope and meaning to life"-as one general nursing diagnosis related to spirituality. Additional characteristics of spiritual distress include questioning the meaning of life, death and suffering; questioning credibility of the belief system; discouragement or despair; and emotional detachment from others and self. Factors that contribute to spiritual distress may be pathologic, treatment-related or situational (e.g. death or illness of the significant other) (Van Dover and Bacon, 2001; Green Street, 1991; Carpentio, 2002).

The North American Nursing Diagnosis Association defines spiritual distress as the disruption in the life principle that pervades a person's entire being and that integrates and transcends one's biological and psychosocial nature (2001). Gulanick *et al*. (2003) defines spiritual distress as an experience of profound disharmony in the person's belief or value system that threatens the meaning of life. During spiritual distress, the patient looses hope, questions his or her belief system, or feels separated from his or her personal source of comfort and strength. Pain, chronic terminal illness, impending surgery, death or illnesses of a loved one are crises that may cause spiritual distress. Being physically separated from family and familiar culture contributes to feeling alone and abandoned.

O'Brien (2004) stated that a patient who questions the reason for suffering may be experiencing spiritual distress and identified seven nursing diagnoses involving spiritual

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issues: spiritual alienation, spiritual anger, spiritual anxiety, spiritual despair, spiritual guilt, spiritual loss and spiritual pain. Characteristics indicating appropriateness of the diagnosis include questioning the meaning and purpose of life and one's relationship with God; expressing guilt feelings and anger toward God; refusing to participate in usual religious practices; regarding illness as God's punishment and seeking spiritual assistance.

Nurses are the one professional group that are most consistently with and accompanying patients during their stay in hospital and are best placed for early identification of spiritual distress. Spiritual distress can be not only painful and a cause of anguish to patients, it can rob them of positive motivation. Nursing leaders have long advocated that nurses need to satisfy their clients' spiritual needs and improve their spiritual well-being (Henderson, 1961; Travelbee, 1971; Macrae, 1995; Neuman, 1995). They further remind nurses that when illness, loss, grief, or pain strikes, not only person's physical energy depletes but his spirit is also affected, with a consequent intensification of spiritual concerns and needs. It is therefore suggested, that nurses should prepare themselves to assist individuals and families not only to cope with illness and suffering, but also to find meaning in these experiences. The nurse therefore, has an important assessment role. The nurse is the one in-hospital health professional who has the most immediate and consistent relationship with the patient and is ideally placed to assess the patient's state of spiritual well-being or lack of it. Because early identification aids the provision of an appropriate response, the restoration of a sense of well-being and a positive health outcome.

REVIEW OF RELATED CONCEPTS

Spirituality: For the reason that spirituality is the lens through which spiritual distress can be viewed, a clear definition of spirituality is needed. Contemporary existentialism emphasizes that spirituality is a universal phenomenon. Each individual is capable of actualizing this unique potential, that is, the spiritual component (Narayanasamy, 1999). In another view from the humanistic perspective, the concept of God does not constitute a transcendent being or a set of religious beliefs. Instead, the person has consciously or unconsciously chosen a set of values, which becomes the supreme focus of life, around which life is organized (Carson *et al*., 1986). From this perspective, it may be argued that the perceived values embraced by the individual have the ability to motivate the individual's lifestyle towards fulfillment of their individual needs, goals and aspirations, leading to the ultimate achievement of self-actualization (Oldnall, 1996). Further, this process of self-actualization encourages the individual towards a spiritual quest that is unable to exist outside the human plan and is solely dependent on the individual's ability to be self-sufficient. Thus, from these two perspectives, it is apparent that each individual has spiritual needs regardless of whether the individual is religious or not (Seaward, 1995). Spirituality can be viewed as a quality, which goes beyond religious affiliation that strives for inspirations, reverence, awe, meaning and purpose, even in those who do not believe in any God. The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinity and comes into focus when the person faces emotional stress, physical illness or death' (Murray and Zentner, 1989). These definitions seem to be reasonable compromise in that spirituality has a universal application and is not concerned to a religious connotation. They embrace the needs of believers and nonbelievers and apply to contexts where religious beliefs may be varied.

However, according to Rassool (2000) in Islam and following the holy Quran and Hadiths (sayings, deeds or agreements of the holy prophet) there is no distinction between religion and spirituality. The concept of religion is embedded under the umbrella of spirituality. In the Islamic context, there is no spirituality without religious thoughts and practices and the religion provides the spiritual path for salvation and a way of life. Muslims embrace the acceptance of the divine and they seek meaning, purpose and happiness in worldly life and hereafter. This is achieved through the belief in the oneness of Allah without any partner and the understanding and application of Qur'anic practices and the guidance of the holy prophet (Mohammad). The material realm of the world is given in trust from Allah. Tawheed means ``unification'' and is used in reference to Allah. It means the realizing and maintaining of Allah's unity in all of man's actions which relate to Him directly and indirectly. It is the belief that Allah is one, without partner, one without similitude in His essence and attributes and one without rival in His divinity and in Worship. These form the fundamental basis of Tawheed. The material realm of this world is given `in trust' from Allah. In this model, Allah's unity must be maintained spiritually, intellectually and practically in all facets of human life. Philips (1994) maintains that monotheism, as brought by the prophets of God, was not merely a theory to be philosophically appreciated or emotionally championed, but a pragmatic blueprint for human existence in submission to the will of almighty God, Allah (Rassool, 2000). As well according to Rahman (1980)

the spiritual discipline `which educates and trains the inner self of man is the core of the Islamic system. It also frees man from the slavery of the `self', purges his soul from the lust of materialistic life and instills in humans a passion of love for Allah. It is through the process of patience, perseverance and gratitude that opens the door for spiritual and physical well-being.

Islam and health: The word 'Islam' means submission to the will of Allah and a Muslim is a person who submits to the will of Allah. In addition, Islam carries many meanings; one of them is peace that includes inner peace (peace with oneself); peace with the creator, as well as peace with all creation. It is through the total submission to the will of Allah that one reaches this form of peace (IQRAA, 1995). In Islam, illness and disease may be regarded as a test from Allah but carries tidings of forgiveness and mercy (Al-Jibaly, 1998). Therefore, a sick person should be stoical but may pray to Allah to reduce her suffering. Thus, the worldview of Muslim patients towards health and illness incorporates the notion of receiving illness and death with patience, meditation and prayers. Muslim patients understand that illness, suffering and dying are part of life and a test from Allah. In addition, Illness and reflection may help individuals to grow spiritually-a concept that is in harmony with Islamic belief systems as described by Rassool (2000). He argues that the concepts of holism and spirituality are at the centre of Islamic beliefs, stating that: Islamic teachings and practice have enabled the production of a holistic framework in meeting the physical, spiritual and environmental needs of individuals and communities (Rassool, 2000).

For nurses, charged with the care of an increasing number of Muslims, an understanding of how their perception of health and illness are influenced by their faith is important. Rassool (2000) highlights that for Muslims, health and illness becomes part of the continuum of being and prayer remains the salvation in both health and in sickness. Hence, supporting the Muslim Patient's spiritual needs is important in improving his/her health. Additionally, learning to care for people in the context of their culture and religion is an aspect of palliative and transcultural nursing care (Andrews and Hanson, 1999).

Iranback ground to health care provision: Iran is a large country in the Middle East. The present population is approximately 69.5 million (United Nations Information Centre, 2005). The demographic profile indicates that 51% of the Iranian population is less than 20 years old. In addition, Iran's life expectancy has risen to 67 years for men and 72 years for women (WHO, 2005). Iran is a multicultural society with many language groups. Since the Iranian Revolution of 1979, millions of Persian speaking peoples from different faiths have migrated to other parts of the Middle East, to the US, Europe and other areas of the world. According to the Persian Diaspora Census, up to 1996, the total number of migrated people had been 4167 000 (Persian World Outreach, 2005).

The Ministry of Health and Medical Education in Iran oversees an extensive healthcare network that offers basic medical services in addition to public health programmes such as primary, secondary and tertiary health care and education of medical groups. Private providers offer secondary and tertiary healthcare services.

In Iran, taxpayers are eligible for health insurance, which covers both physical care, hospital care and drugs. Most of the pharmacies and physicians employed by the Ministry of Health and Medical Education are willing to bill the insurance companies directly; however, many medical specialists do not bill directly. University hospitals and health clinics are considered public hospitals and clinics admit everyone regardless of insurance status. These institutions are viewed widely as reliable and inexpensive and as a result, have long waiting lists. However, the story is different for private hospitals and clinics whose facilities are considered much better. Patients pay for treatment in cash. In addition, the military have their own hospitals, health centers, physicians and their own training programmes for physicians, nurses, practical nurses and licensed practical nurses (Cheraghi *et al*., 2005).

MATERIALS AND METHODS

Design: To gain access to the spiritual distresses experienced by patients, qualitative descriptive research was conducted using unstructured Interviews.

Aim and objective: The purpose of this investigation is to explore the antecedents of spiritual distress experienced by Muslim patients in the Islamic context of Iran.

Sample: The specific data source selected for this study was Iranian Hospitalized patients and their carers in a community hospital setting. All patients admitted to the units were considered against the inclusion criteria, which were aged over 12 years, with a minimum of a week's experience of the service and able to give informed consent. Patients admitted to the units and fitting the criteria were approached to take part in the study. Twenty-one patients and three relatives were interviewed.

Ethical considerations: University's Research Ethics Committee approval was received in writing before the study was started. In order to protect the interests of the group, we were committed to the ethical principles of autonomy, non-maleficience and beneficence (Beauchamp and Childress, 1994).

Informed consent: Patients were approached by first author and asked to take part in the study. An information sheet used to describe the study. The patients' understanding of the study and their right to refuse to participate were explored. The consent process was witnessed by a member of the nursing team and recorded in the patient notes.

Patients were given a minimum of 1 day to consider participation and for nursing staff to discuss the study with their families. If the patients and their families were still willing to participate, a date and time for the interview were set. Family members were invited to attend the interview.

Data analysis and findings: Audiotaped interviews were conducted in the hospital with questions asked to encourage patients' responses in a narrative form. The questions were related to their experiences of spiritual distress. Interviews were transcribed and open coding system was used to generate preliminary categories.

RESULTS

Personal details were obtained on gender, age, marital status, number of children living at Home, Diagnosis and length of staying in hospital. The description of their characteristics have shown in Table 1.

Open coding stage involved reading the transcriptions several times and underlining common or salient themes. Then they were given a title, either a term used by the patients or one generated by the researchers. Then some of participants were interviewed again to discuss the doubtful answers they have given in the first interview. In this stage, primary codes generated and the sample of these codes has shown in Table 2.
Below some narratives have given for easy audit:

Example 1: I have been here since three days ago, I didn't pray anyway, I 'm so sad about that, tell them to give me clean trousers.

Codes that extracted from this excerpt include:

- Feeling distress
- Need to cleanliness
- Need to pray

Table 1: Demographic characteristics of subjects

	N	(%)
Gender		
Male	14	58.33
Female	10	41.67
Marital status		
Single	8	33.33
Married	16	66.77
Children living at home		
0	10	41.67
1	4	16.66
2	3	12.50
3	2	20.84
4	1	2 8.33
Age		
18-28	3	12.50
29-38	4	16.66
39-48	8	33.33
49-58	6	25.00
59-68	3	12.50
Diagnosis		
Heart disease	8	33.33
Cancer	5	20.84
General surgery	6	25.00
Trauma	2	8.33
Companion	3	12.50
Length of staying at hospital (days)		
4		
7	6	25.00
12	5	20.84
15	3	12.50
More than one month	5	20.84
companion	2	8.33
	3	12.50

Table 2: Sample of open codes

Caring as a machine
Caring by men
Dirty environment
Being cared in the presence of people
Sense of guilt
Fear of death
Fear of dependence
Expectation from family
Haven't ability to worship
Feeling insecurity
Feeling loneliness
Feeling unworthy
Loss of integrity
Prison in pain
Interruption in privacy
Loss of relationship with family members

Example 2: Nurses have not a suitable communication with patients, they are good with each other but not with patients; communication has great effect. Drug may have not effect on patient, communication, a chat have more effect than a pill of acetaminophen to headache. Nurses talk with each other well, but in the case of us, only one word. They do not give a chance to talking patient or his (her) companion.

Codes that related to this narrative comprise:

- Lake of suitable communication with health care professionals.
- Need to have communication.

In the next step, codes that had common criteria were given similar label. The list of codes that categorized in this step has shown in Table 3.

Description of categories: Therefore, at the end we find four categories as antecedents of spiritual distress in Iranian Muslim patients. They are including failure in communication, illness, non- holistic care and inability to worship.

Failure in communication: In the hospital, patients experience spiritual distress because of non-satisfying communication. They have problem with the health care team, their own family, friends and with the life entirely.

Failure in communication with health care team: Communication with the health care team is vital for patients. They get care, information and support from health care team while hospitalized. Failure in communication with them leads to negative feelings and spiritual distress in patients. One of patients stated: Nurses have not good communication with patient(s), they are good with each other but not with patient(s), communication has a great effect. Drug may not affect the patient, but communication, may have more effect. For instance, a chat could have a more result than a pill of acetaminophen to headache. Nurses talk with each other well, but in the case of us, only one word. They don't let the patient or his (her) companion any to talk " (S 2).

Failure in communication with family: Unfortunately, in Iran hospitals nurses have not adequate time and energy for building communication with patients. Therefore, family has crucial role in meeting the needs of hospitalized patients. In the case of failure in communication with the family patients experience a great deal of pressure and distress as illustrated by the following excerpt: "They tired of my disease, they tired of caring all the time, so they don't care about me. I know, my illness id hard one, they cannot care all the time but I need them. I have not anyone to care of me. I took them in trouble I am guilty; they can't make their own works and hobbies because they have to care of me"(S 13).

Table 3: Codes level 2 and 3

Codes level 3	Codes level 2
Failure in communication with health care team	Failure in communication
Failure in communication with family	
Failure in communication with life	
Failure in communication with friends	
Biomedical care	Non-holistic care
Non humanistic care	
Being cared by opposite sex	
Physical inability	Inability to worship
Lack of worship utensils	
Lack of privacy	

Failure in communication with friends: In the case of illness, patients need to be supported. This support comes through communication with family and friends. Some of patients have not ability to go out with their friends and have good communication with them. Because communication is mutual, this leads to failure of communication. One of patients said: "I haven't a friend. Friends want to have gain but I have not any benefit to them. So they don't care about me"(S 10).

Failure in communication with the life: One of patients stated: "I do not have the relation with life as the past. I do not enjoy from living as usual. Hospital reminds me sorrow and pain. I feel dead in hospital. There is not any life in hospital for me" (S 4). This saying shows the broken relationship between patient and life. This is annoying for patients because they cannot enjoy the usual life.

Non-holistic care: Traditional biomedical care, Non-humanistic care and being cared by the opposite sex were among factors causing spiritual distress in subjects. Traditional care is very distressing for patients because of stressing only on disease, not on patient as a whole. Some times health care professional give non-humanistic care. Humanistic care includes paying attention to patient, being present and available for patient and caring with respect and dignity. Patients stated that they being cared without these qualities. One of subjects said: They just their work with heads below, without any word. They don't speak with us, only one word. Yes or No.

Inability to worship: Most patients had problem in doing their worship. Physical inability, lack of privacy and worship utensils were among barriers of doing worship. In the Iranian culture, privacy includes modesty (hijab), separation of men and women, caring by same sex and a private place to worship. Modesty is very important for both sex but especially for women." If I had remedy, I would not stay here (hospital). (There is) no prayer and no modesty (hijab). Men are allowed to enter the women ward. No one had seen my hair till now" (S 19).

Another patient confirmed, "If you want to solve problems, the main one is this toilet. There are only two toilets for entire ward. Men and women go to the same one. Toilets should be separated. This is the most important issue " (S 23).

DISCUSSION

In this study, most of patients and family members were in distress because of unsuitable communication

with health care professionals. Moore and Schwartz (1993) have observed a pattern of poor communication among nurses at an emergency department in the study. In their study, nurses reported that they communicate verbally and non-verbally with the trauma victim, but the researcher observed that the nurses delivered less psychosocial support than they reported. Communication is integral to the process of caring and is an essential part of the care of critically ill patients (Jafar and Muayyad, 2005). The professional's responsibility for developing a trusting relationship, for an open, positive attitude and for sensitivity to relatives' need for information/ communication/education and support has described in many studies, as was the importance of these factors regarding the situation of relatives (Carter, 2001; McGrath, 2001; Harding *et al*., 2002). But many studies reported that information and communication were inadequate and insufficient (Dunne and Sullivan, 2000; Rogers *et al*., 2000; Bolmsjo and Hermeren, 2001; McGrath, 2001; Broback and Bertero, 2003). In a survey study, the majority of relatives' comments concerned dissatisfaction with communication and information (Rogers *et al*., 2000).

Moreover, the nurse needs to recognize the central importance of the family in taking care of patients of Islamic denomination (Luna, 2002) and that the inclusion of the patient's family in the planning of care is essential to the delivery of culturally competent care (Leininger, 1981). In Iran, the family is the traditional foundation of society that extends beyond the immediate relatives to include all the members of the tribe. The reality that the Muslim family is the cornerstone in caring' is also found in Omeri's (1997) study of care meanings, expressions and practices of Iranian Muslim immigrants in Australia. As indicated in the present study, family visiting and support (emotional, social and physical) are important ways of 'being together'. In addition, not supporting by family members is a source of spiritual distress. On top, Followers of Islam are obliged to visit a person and to enquire about their health (Johnson, 2001). Nevertheless, the findings of this study support those of Hupcey's (1999), in that nurses viewed families as a distraction to the nursing staff. However, the nurses retained a position of power, as they continued to prioritize the physiological needs as the most important consideration. The priority of physical care is also emphasized in Jafar and Muayyad's (2005) study of the communication of Jordanian critical care nurses with critically ill patients, which indicated that nurses preferred to care for sedated or unconscious patients, as they are considered 'less demanding'.

A number of studies described how relatives had to feel their way forward to get information, they had to be obstinate and ask questions. In addition, information was often difficult to get (Andershed and Ternestedt, 2001; Rogers *et al*., 2000; McGrath, 2001). It was also hard for relatives to pose questions when they did not know what to ask. When they lacked knowledge, felt uninformed and did not know what was going to happen, relatives often felt isolated, disillusioned, frustrated, distressed and had difficulty handling the situation (Andershed and Ternestedt, 2000; Dunne and Sullivan, 2000). The studies indicated a great need for information and communication Medigovich *et al*. (1999) found that dysfunctional families could benefit from increased communication, thereby avoiding feelings of dissatisfaction with the care. (Dawson and Kristjanson, 2003).

Non-holistic care was another source of spiritual distress in Iranian Muslim patients. In this study, patients treated only for physical distress. Emblem and pesut (2001) states that Extrinsic barriers for providing spiritual care include the inherent precedence of biophysical care priorities that often limit provision of holistic care and lack of theoretical nursing models to assist nurses with this responsibility.

Dossey and Keegan (1989) defined holism as 'the view that an integrated whole has a reality independent of and greater than the sum of its parts.' This is echoed in Bradshaw (1994, xix) 'A way of thinking, stressing that the whole is more than the sum of its parts and cannot be broken down into parts and analyzed (Driscoll, 2004). Neuberger (1998) asserts 'We are actually whole people and we need to be recognized as whole people. Hence training and then practice, for health professionals should recognize that wholeness and respond to it, including recognizing our need for spiritual care.

Dossey (1998) writes, We may specialise and subspecialise, but our patients don't. They come to us a whole, not as a body cut off from their soul and spirit. And it is the whole to which the nurse responds, if she deserves to be called a nurse instead of a technician.

Koenig (2000) has written, Patients want to be seen and treated as whole persons not as disease. A whole person is someone whose being has physical, emotional and spiritual dimensions. Ignoring any of these aspects of humanity leaves the patient feeling incomplete and may even interfere with healing.

Quality holistic care requires that time is spent with patients listening to their individual stories. This is holistic history taking. This story tells us that we are part of an ever-expanding universe and it is a story that continues to unfold around us and within our own lives. The world of quantum physics tells us the story of subatomic particles and that story is that particles are entangled. American poet Muriel Rukeyser has written

that 'the universe is full of stories, not atoms. Every human person, every being, every thing has a story, contains a story and is a story. In addition, each person's story interconnects with other stories. Encouraging patients to tell their stories can be of considerable value. Apart from anything else, spending time listening enables us to get to know the other person and what is important in their lives. It is one way we can get to know their spirit and spirituality. Verghese (2001) believes that 'all the patients we see, no matter how often we see them or how benign we consider their illness to be, are in the midst of a story. For patients the story begins the moment they walk through the portals of the hospital or through the doors of our clinics. When they go to buy groceries, when they drop their children off at school, there is no story. However, when they see the physician, the three D's lurk in the background. There is danger in the visit, they have the desire not to hear bad news; and therefore, there is drama- and therefore there is story.' Luker *et al.* (2000) stress the importance of 'knowing the patient, describing the quality of the interaction between patient and nurse as being at 'the very heart of nursing'. Radwin (1996) provides an overview of the importance of knowing the patient. The reasons for doing so are many but at their heart is the fact that knowing the patient and the patient's perception of their situation can aid the nurse in interpreting concerns and/or in anticipating needs (Driscoll, 2004).

This result is in concordance with the Highfield's study who discussed the fact that, although nursing prides itself in caring for the whole person, spiritual needs of the patient has not been adequately addressed. In that study, Oncology inpatients and oncology nurses were surveyed to assess the spiritual health of patients and the ability of nurses to assess this phenomenon. Older patients with fewer distressing symptoms experienced a higher degree of spiritual health than younger patients with distressing symptoms. Overall, oncology patients reported moderately high levels of spiritual health. There was no relationship between patient reports and nurse's observations of the patient's spiritual health.

Another antecedent of spiritual distress experienced by subjects of this study was inability to worship. In this people, worship was a way of self-preservation from the suffering and connecting to sacred for finding meaning. In Karimollahi *et al.* (2007) study, worship was the most stated spiritual need among Iranian Muslim patients. As described by Labun (1998), spiritual needs can be met through traditional religious acts, such as rituals, prayers and worship. These rituals provide meaning to everyday life and help patients through hardships such as pain, illness and personal disasters. These needs are influenced by ethnic and cultural backgrounds and met by a set of cultural practices. Therefore, it is obvious that, inability to do worship can make a great deal of distress in these patients because it disturbs sense of connectedness with sacred. Since Burton (1988) offers the following definition: Religion is a cultural phenomenon, involving mutually interacting systems whereby symbol, myth and ritual serve to organize and bind personal and group anxiety about nonbeing to validate norms and behavior through reference and in relation to commonly shared conception of the ultimate. Rather Ellis (1987) describes spiritual care in religious terms as praying and Bible reading, whereas Karns (1991) states that spiritual care includes all the nursing care that supports a patient's religious practice, personal beliefs and values. Thus, in these studies religion constitutes the central part of the spiritual/ existential dimension.

Methodological aspects of the study: We did the content analysis individually and then compared the results. We did not calculate agreements in percentage, which could have strengthened reliability.

As this is a qualitative study, the findings cannot be generalized to all caring situations and patients. One qualitative study alone will not provide the whole picture of nurses' caring behaviour when caring for patients.

CONCLUSION

It can be said that staff members have a great deal of responsibility for assuring that the patient feels as good as possible, facilitating relatives' involvement based on the family's wishes and limiting the stress and difficulties experienced by the family. The results showed that the patient's satisfaction could depend on good communication, good listening and good information. This study indicated that nurses need to improve nurse-patient communication. Open communication, listening and being present are valued nursing interventions.

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